Changes in the Health Services Industry

The Industry: Not What It Use to Be

Unlike many service industries, the health services industry experienced a slowdown in employment and wage growth in recent years, even as it continues to be a major source of new jobs in the United States. The Nation's health care system underwent a major transition in the way health care was financed, where care was provided, and how care was delivered. Strategic bargaining by large insurers and the managed care industry helped to bring increases in health prices in line with overall inflation.

Table 1. Annual percentage rate of increase in average hourly earnings, total services, and selected services industries, selected years, 1987-98

Industry	Percent growth			1998 annual average (dollars per hour)
	1987-92	1992-97	1998	
Services	4.4	3.1	4.6	$12.84
Health services	5.5	3.1	3.5	13.72
Offices of medical doctors	5.8	3.8	3.6	14.28
Offices of other health practitioners	6.7	4.6	5.1	13.13
Nursing and personal care	5.6	3.5	4.5	9.76
Hospitals	5.8	2.9	2.9	15.46
Home health services	8.2	2.6	1.3	11.50
Business services	2.7	3.5	6.1	12.55
Personnel supply	2.7	2.8	5.3	10.33
Computer and data processing	5.2	4.9	5.3	21.16
Engineering and management services[1]	4.3	3.3	4.2	17.86
Amusement and recreation[1]	2.3	2.7	5.6	9.67

[1]Data series began in 1988; therefore, the average shown is a 4-year average in the 1987-92 period.
Note: Data are for nonsupervisory workers.
Source: Engel, C., 1999, Health services industry: Still a job machine? Monthly Labor Review 122(3):3-14.

The primary health service industries are offices of medical doctors and other health practitioners, nursing and personal care, hospitals, and home health care. Federal reimbursement policies for home health care and nursing homes were revised during the late 1990's, and many individuals shifted from fee-for-service to managed care insurance plans. Most of the increase in health care jobs over the 1987-97 period came from hospitals and from offices and clinics of medical doctors.

Growth, Reimbursements, and Cost Containments

In terms of *rate of growth* during the 1987-97 period, home health care surpassed all other components of the health services industry. Medicare expenditures for home health services grew at an average annual rate of 28.6 percent between 1990 and 1996, but this was projected to have slowed to 0.2 percent annually between 1996 and 1998. Regarding cost controls, false claims in the medicare program were aggressively targeted in 1997 by the Health Care Financing Administration. The greatest rate of fraud was found in nursing homes and home health care services.

Prior to July 1998, reimbursements varied widely for medicare patients with the same diagnosis and were not adjusted for the clinical conditions of the patient. After July of that year, the prospective payment system in the nursing home industry was established; medicare reimbursements had to reflect the average cost to treat patients by diagnosis. At first, a facility-specific rate and a Federal rate could be blended. By 2002, all nursing facilities will receive a single Federal rate to charge by diagnosis of the patient.

Hospitals have operated under the prospective payment system since 1983; reimbursements were based on diagnostic groupings of illnesses and, as a result, operating costs were reduced—in part, through greater control of labor costs. Further efforts by the Federal Government to control rising costs in medicare continued with the implementation in 1992 of a physician fee schedule.

Cost-containment efforts affected employment and wage growth in the medical services industry. In 1998, the rate of growth in average hourly earnings for nonsupervisory workers in health services was only half of its 1987-92 pace. Still, the average of hourly earnings was greater than the average for all workers in the services industry in 1998 ($13.72 vs. $12.84) (table 1). Also, the number of paid hours throughout the health care industry increased. Over the decade, home health services, compared with other services in this industry, increased the average workweek the most. The growth in worker hours in the health

services industry is particularly significant when compared with almost no growth in the average workweek for all services industries (table 2).

Table 2. Annual average growth in hours, 1988-98

Industry	Hours 1988 annual average	Hours 1988-98 change
Services	32.4	0.3
Health services	31.6	1.5
Offices of medical doctors	31.6	1.3
Offices of other health practitioners	29.6	0.6
Nursing and personal care	31.6	1.0
Hospitals	34.0	1.0
Home health services	26.5	3.5

Note: Data are for all nonsupervisory workers, both full- and part-time employees, and include all hours for which workers are paid (hours of work and paid leave hours).
Source: Engel, C., 1999, Health services industry: Still a job machine? Monthly Labor Review 122(3):3-14.

The Quest for Efficiency

Types of Health Plans

The higher increases in hourly earnings between 1987 and 1992 occurred at a time when health care was predominantly fee-for-service. The slower wage growth between 1992 and 1998 corresponds with the shift to managed care.

In a fee-for-service arrangement, the insured may choose the health care provider and service, and fees are submitted to the insurer when care is delivered. Any licensed provider may be used, including very specialized physicians. Thus, providers are subject to fewer cost controls than under other types of arrangements.

Preferred provider organizations (PPO's) represent groups of providers who have negotiated discounts with insurers. These plans offer participants a higher rate of reimbursement for choosing from a designated list of participating physicians. Though considered a form of managed care, PPO's are similar to fee-for-service plans in that services are reimbursed following treatment (subject to a deductible), and there is an out-of-pocket expense limit. A primary care physician is not required nor are referrals for appointments with specialists.

Health maintenance organizations (HMO's) have the dual role of health provider and insurer. HMO's have a prepaid fee that covers most medical procedures. In addition, the insured pay a small copayment. HMO's require the insured to be screened by a primary physician for most treatments, while also providing more complete coverage for preventive care and routine physicals. As a result, HMO's often provide less expensive health insurance to the insured. According to a survey of the American Medical Association, the percentage of physicians having contracts with one or more managed-care companies grew from 88.1 percent in 1996 to 92.3 percent in 1997.

Medical Care Costs

Inflation of medical care, as measured by the Consumer Price Index (CPI), far exceeded the rate of inflation of other goods and services over the 1989-95 period. In 1996-97, price growth of medical care slowed, approaching the rate of growth of other goods and services. Consumers' health care costs are split between insurance premiums and out-of-pocket costs, which include drugs, medical supplies, and services. Despite average annual increases in insurance premiums amounting to 6.1 percent between 1990 and 1996, the average annual increase in the total health care bill was only 3.0 percent during the same period. Declining price growth resulted from shifting care from inpatient facilities to outpatient settings, consolidating acute care facilities within the industry, and conducting more studies on processes in hospitals.

Hospital Restructuring

Jobs of hospital personnel were reorganized to reduce idle time and the number of staff-member contacts per patient. Nurses became "resource coordinators," and staff were trained in several skills. In a survey of registered nurses, practical nurses, physical therapists, and occupational therapists, more than half reported they did not have enough time to spend with patients; 38 percent said their facility was understaffed. However, one-third reported staffing levels as either excellent or good. The most frequently mentioned contributor to a lower quality of care was the closing of urban hospitals and clinics; the second, expansion of managed care.

Length of Hospital Stay

Government and private insurance policies have lowered reimbursements to hospitals for inpatient services and increased reimbursements for home health and outpatient services. Hence, costly hospital stays have been shortened. Reductions in average length of stay have occurred for all age groups except those under age 15. Between 1985 and 1996, the average length of stay for those 85 years and older declined by 2.6 days, compared with 2.2 days for those aged 65 and older and 1.7 days for those aged 45-64. As

lengths of stay decreased, cost growth was greater than average in the post-acute settings of skilled nursing facilities, home health services, and hospice care.

Effect of Demographic Changes

As the elderly population continues to grow, demand for medical and personal services will increase. Although medicare provides only about half of the personal health care expenditures of the elderly, public funds contribute a larger share of personal health care costs as the population ages. The portion of health care costs that the Federal Government paid increased from 24 percent in 1970 to 34 percent in 1996 (table 3). More persons are living longer while they are eligible for medicare, contributing to larger Federal expenditures. Also, new and improved treatments have increased demand from this group. In 1970, 20 percent of hospital discharges and 33 percent of the days of care in hospitals were for persons aged 65 and older; in 1994, these percentages had grown to 37 and 47 percent, respectively.

To contain cost growth, medicare is turning to managed-care arrangements. Because managed care was limited to the HMO option prior to 1998, participation among medicare enrollees was only at 12 percent. The Balanced Budget Act of 1997 contained provisions that expand medicare's managed-care options. Managed care is more prevalent for the elderly in medicaid than it is in medicare, covering 40 percent of those enrolled in 1996 and 48 percent in 1997.

Effect on Health Care Occupations

Managed care has placed more control in the hands of generalists who typically are general practitioners, physician assistants, and nurse practitioners. Most often, generalists treat patients or refer them to specialists. According to a study of medical journal recruitment ads, the ratio of advertisements for specialist positions to generalist positions dropped from a peak of 4 to 1 in 1990 to 1.8 to 1 in 1995. Between 1984 and 1995, only family medicine practitioners exhibited continuous growth, because care plans required the use of generalists. This is reflected by the choices of new medical residents—more than half of whom in 1998 began residencies in generalist programs.

Where gaps exist, physician assistants provide health services otherwise provided by physicians, such as conducting complete physicals, providing treatment, and counseling patients. In 44 States, they are permitted to write prescriptions. Over the last 10 years, the number of graduates who became physician assistants has more than doubled to about 4,000 per year. Because the median annual income of physician assistants is only about half that of doctors, health care costs are reduced while the quality of care provided for authorized procedures is maintained—according to a study by the Congressional Office of Technology Assessment.

Between 1983 and 1994, the ratio of registered nurses per hospital bed increased by more than 50 percent. During this period, the workload of nurses increased because they cared for patients with more acute illnesses and whose average length of stay became shorter. However, a declining rate of growth in hospital employment led some nurses to seek jobs in other sectors that paid 10 to 20 percent less than those working in hospitals in 1994. The rate of employment growth between 1988 and 1994 for registered nurses was 26 percent in nursing homes, compared with 16 percent in hospitals. According to the Current Population Survey estimates of weekly earnings, registered nurses' earnings continued to decline through 1997 when adjusted for inflation. Coupled with the other occupational changes, a slowing of growth in hospitals and increased bargaining power of insurance companies, the health services industry has experienced a slowdown in wage growth.

Source: Engel, C., 1999, Health services industry: Still a job machine? *Monthly Labor Review* 122*(3)*:3-14.

Table 3. Percent distribution of personal health care payment sources, selected years

Source of payment	1970	1980	1990	1996
Total (billions of dollars)	73.2	247.3	699.5	1035.1
Total (in percent)	100	100	100	100
Private funds	62.2	57.6	59.3	53.3
Private health insurance	3.7	4.8	5.8	5.9
Public funds	37.8	42.4	40.7	46.7
Federal	24.3	29.1	28.0	33.9
State and local	13.5	13.3	12.7	12.8

Note: Data exclude administrative, research, construction, and other spending that is not directed towards patient care.

Source: Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary and Office of National Health Statistics.